

# Key Strategic Trends that Impact Healthcare Decision-Making and Stakeholder Roles in the New Marketplace

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After the passage of the Affordable Care Act (ACA) in 2010, market changes beyond those already in play began to emerge. Traditional roles, responsibilities, and authority of various healthcare stakeholders could now be tested or altered as a result of some sections of the ACA. One result is that healthcare providers could now share in the savings, take risk, and form relationships that were previously barred or were nebulously forbidden.

Among some of the often mentioned trends have been accountable care organizations (ACOs), the formation of large hospital health systems, and the continuation of private insurance coverage by self-funded employers. However, the marketplace had undergone many subtle changes that began before the ACA, which only accelerated after its passage. In fact, one trend is that change has been occurring at a rapid rate throughout the various healthcare stakeholders.

Tracking the emerging trends and tracing innovation patterns in the post-ACA marketplace in 2014 has led to the identification of several high-level strategic trends that are or will be increasingly significant. The trends that will increasingly impact multiple healthcare stakeholders over the next few years (through 2018) include:

1. Patients becoming more informed consumers
2. Growth of structured quality measures
3. Revenue-driving consolidation
4. New and alternative provider payment models
5. Specialty drug use driving the cost of care
6. Information technology innovations driving inter-stakeholder communications.

The following discussion details some insights into each of these key market trends that impact multiple healthcare

stakeholders and will continue to affect decision-making and relationship dynamics.

## Patients as Consumers Making More Informed Healthcare Choices

The old healthcare model of treating acute illnesses is evolving into a model with increasing focus on the patient, disease prevention, and the ongoing management of chronic diseases. Today's healthcare market allows consumers to take charge of their healthcare in a new way. Readily accessible data and information allow patients to have open dialogues with their doctors about diagnosis and treatment options. Cost estimators increasingly help consumers understand the intersection of cost and quality in assessing their care options. Market exchanges for health insurance let people choose from a large variety of insurance coverage plans and options.

A movement toward personalized health treatment is also developing through the advancement of genetic, behavioral, and digital tools that are designed to monitor and manage personal health.

Health insurance products and benefit structures that increase consumerism are helping to manage benefit costs. With the increased financial responsibility, consumers are reevaluating how and when to spend on healthcare services. The 2014 Employee Benefit Research Institute/Greenwald & Associates Consumer Engagement in Health Care Survey found that 26 million individuals with private insurance were enrolled in a consumer-directed health plan (CDHP), a health plan associated with a health savings account (HSA) or health reimbursement arrangement (HRA), or an HSA-eligible health plan.<sup>1</sup>

This study found evidence that adults in a CDHP and those in a high-deductible health plan were more likely to exhibit cost-conscious behaviors than adults in a traditional plan. Specifically, CDHP members were more likely to say that they had checked whether the plan would cover care, had asked for a generic drug instead of a brand-name drug, had talked to their doctors about pre-



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scription options and costs, had checked the price of a service before getting care, had asked a doctor to recommend less costly prescriptions, had talked to their doctors about other treatment options and costs, had developed a budget to manage healthcare expenses, and had used an online cost-tracking tool provided by the health plan.

Changes in the healthcare marketplace going forward are requiring patients to spend more of their own money on their medications. They are no longer uninvolved players in the selection of treatment and the use of drugs or health services. The pharmaceutical industry is discovering that it is important to understand the behavior of its consumers if it wants to meet sales expectations. Drug manufacturers can no longer expect to have commercial success by simply proving that their drugs meet the established measures of safety and efficacy with traditional clinical customers (ie, providers). Manufacturers must now understand consumer behaviors if they want to meet the increasing demands of patient expectations.

One area in particular that already has become more expensive for consumers is specialty medications, which treat complex conditions. It is anticipated that 2014 prescription abandonment rates will continue to rise through 2015, along with the growth of middle-class wage earners who are facing high-deductible plans. Similarly, health systems will continue to struggle with balancing decreasing insurance and/or direct patient-related revenues against the growing cost of diagnostics, drugs, and imaging.

### **Growth of Quality Measures Increases, Becoming More Structured**

Reported by many sources since 2010, the United States spends more on healthcare than any other industrialized country; however, the US healthcare system is not better, and its quality is inconsistent. One reason for this is that the healthcare system is primarily fee for service (FFS), in which providers receive payment for each service rendered, leading to incentives to provide more, not better, services.

The federal government implemented the National Quality Strategy in March 2011 to increase the quality of healthcare and to decrease its cost. Quality measures are increasingly being used to determine how much providers will be paid. Mounting evidence shows that leadership engagement positively impacts healthcare quality.

Several organizations develop and evaluate quality measures, and an even larger number of public- and private-sector organizations use different measures for evaluating and reporting on the performance of providers. Public measure developers include the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality; nonprofit private developers

include The Joint Commission and the National Committee for Quality Assurance. These organizations use a transparent approach to give the public an opportunity to review and comment on their draft measures, to refuse to use proprietary measures, and to make their measure-scoring mechanisms transparent.

Private sector-focused organizations, such as the Leapfrog Group and the National Business Coalition on Health, focus on commercial plan sponsor needs to measure successful plan performance, including quality. Like their public-sector colleagues, these groups operate transparently at the local, regional, and national levels to give real-world data on provider or health plan performance to sponsors and members. These efforts are gaining momentum going into 2015, and have had successes in the market to drive change without publicizing or publishing like public sector agencies.

Many health professional societies also develop measures, such as the American Heart Association, the American College of Cardiology, the Society of Thoracic Surgeons, and the American College of Surgeons.<sup>2</sup> These societies typically publish and promote their measures along with guidelines through membership and industry supporters. Although there have been successes, failures and lack of significant change have remained issues going back to the use of several preventive measures (eg, the flu vaccine, aspirin, and cardioprotective agents), even in the hospital setting. It is more likely that with shared savings and ACOs in the marketplace, more attention will be placed on compliance with proved clinical solutions or treatment guidelines because of the negative economic implications of not following guidelines.

Overall, there is an increasing focus on single measures that are useful across care settings and are more aligned with the entire patient course of disease. Simplifying the large number of similar but different quality measures to more successfully implement change for better clinical and economic outcomes has become a focus going into 2015. The use of quality measures is expanding and increasing the demand for new, innovative care-delivery measures that can deliver desired plan performance by plan sponsors and by patients.

### **Revenue Pressure Driving Healthcare Stakeholder Consolidation**

A fundamental shift in healthcare economic risk is taking place, driven by an aging population and the increasing incidence of behaviorally induced chronic conditions. Health systems, which include people, institutions, and resources that deliver healthcare services to meet the health needs of target populations, are evolving with the market and delivery innovations to meet the challenge of managing healthcare risk through a growing

emphasis on primary care, integrated care models, and pay-for-value reimbursement.

As operating margins continue to narrow, revenue constraints are becoming a pressing issue for many healthcare organizations. Partially in response, health systems are increasing in scale by engaging in horizontal integration through hospital mergers and acquisitions. Scale could drive more efficiency, could improve the spreading of financial risk across the system, and could reduce operating costs across the enterprise.<sup>3</sup>

As health systems consolidate and demand bigger price increases, many insurers are under pressure to not increase premiums. A key way for insurers to keep some of the exchange plans affordable is to exclude more expensive doctors and hospitals from the network, so many consumers will have fewer choices when it comes to selecting their doctor or hospital. These narrow networks have become the current response to expensive healthcare, along with forming ACOs or collaborations on sharing risk.

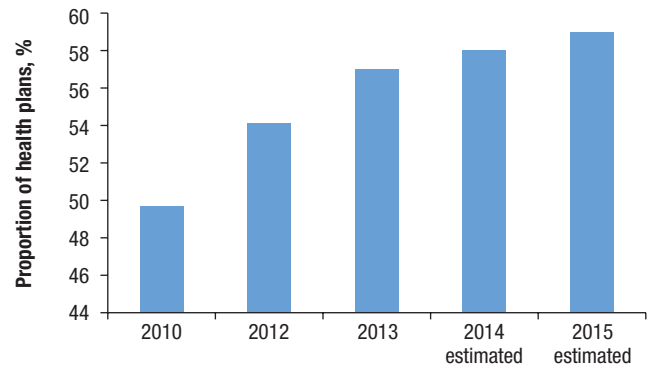
Insurers are worried because larger systems have more clout and command higher payments, and they are building alliances of their own. As an example, Memorial Hermann Physician Network and Blue Cross Blue Shield of Texas are developing an ACO for 100,000 patients. Memorial Hermann Health System is hedging its bets, because it also has an ACO relationship with Aetna and a medical home model with Humana. This is happening in other states, as well as with a number of insurers across the country.

The good news is that these narrower networks will help keep premiums lower, but the unfortunate side effect may be unintended out-of-network bills for patients. Of plans on the exchange, 70% have narrow or ultranarrow networks, with more than 30% of the hospitals in the US metro areas being out of network.<sup>4</sup> This will create an increasing number of access problems for consumers, which is an unintended side effect of the ACA.

Hospitals and health systems continue to acquire physicians. They have the ability to immediately escalate physician charges to the higher hospital rate, which will likely trigger a rise in health plan spending in the next fiscal year. Hospitals and health systems are making these purchases to gain local market share and to develop monopolies.<sup>5</sup> Although some of these payment dynamics will shift again late in 2015 and 2016, the “too big to fail” scenario may prove a valuable lever to use with politicians, because healthcare still remains a local issue.

Employers have been increasingly self-insuring, taking on the claims risk that insurers previously held. Even small employers with as few as 50 to 100 employees are switching to this model in the hopes that they can defray costs and manage their employees’ healthcare spending more effectively on their own. The Kaiser Family Foun-

**Figure** Self-Funded Commercial Health Plans



Source: Access Market Intelligence. Data on file; 2014.

dation and Health Research & Educational Trust’s Employer Health Benefits 2013 Annual Survey and Access Market Intelligence analysis of commercial trends shows that there were 89.1 million fully insured commercial health plan members in 2008, which decreased to 68.8 million members in 2013. At the same time, the number of self-funded commercial health plans increased to nearly 60% of plans (**Figure**).<sup>6</sup>

### New and Alternative Provider Payment Models

New provider payment models are emerging as increased cost pressures are driving payment models away from FFS approaches to those that better align incentives for cost control and high-quality delivery of patient care.

In the next 2 to 5 years, the shift from FFS to value-based reimbursement will be even more dramatic. According to a 2013 Wolters Kluwer Health Survey, 9 of 10 physicians cited shifting reimbursement models and the financial management of practices as their top challenges.<sup>7</sup>

Competition among providers and increasing pressure from public and commercial payers to lower costs and to improve care are driving them away from long-standing volume-based healthcare models and toward value-based care models. These models seek to more fully align payment and objective measures of clinical quality.

The concept of pay for performance (P4P) emerged as a more popular tactic for aligning provider payment with value. Under the typical P4P model, financial incentives or disincentives are tied to measured performance; they may also involve performance thresholds, improvement thresholds, or relative performance cutoffs.

The bundled payment or episode-of-care model provides a single negotiated payment for all services for a specified procedure or condition, such as pregnancy and birth, knee and hip replacement surgery, and certain cardiac procedures.

As a primary care–driven initiative, the medical home focuses on building a team of professionals, such as physicians, registered nurse case managers, medical assistants, and in some cases, pharmacists, that is responsible for coordinating the care of patients across the healthcare continuum.

Shared-savings arrangements represent a potentially higher level of reward for providers. Although per-member per-month payments and FFS rate increases generally cover only the added infrastructure and staff resources, shared savings can be an enticing incentive because providers who offer patient-centered medical homes are often challenged to maintain their previous productivity levels.

### Only approximately 4% of patients use specialty drugs, but those drugs account for 25% of the total US drug spending.

Often combined with FFS, P4P, bundled payments, global payments, or capitation, shared-savings programs reward providers who reduce their total healthcare spending on patients below an expected level set by the payer. The provider is then entitled to a share of the savings.

Shared-risk models could be described as the “next level” of risk arrangement that will be seen in the market, under which providers receive performance-based incentives to share cost-savings combined with disincentives to share the excess costs of healthcare delivery. Expect 2015-2017 to be a period of continued risk experimentation, especially in private-sector commercial insurance arrangements.

Although these new models have the potential to encourage care coordination, improve quality, and control costs, there are many challenges in implementing them. Many of the new models are being implemented by adjusting the FFS payment rather than replacing it, and their potential to be truly transformative may be limited. The success of new payment models will depend in part on identifying and incorporating lessons learned by early adopters.<sup>8</sup>

### Specialty Drug Use Is Driving the Cost of Care Trend

Innovations in biologics and so-called specialty drugs are beginning to enter the market at a more rapid pace as the research pipeline continues to grow. Only approximately 4% of patients use specialty drugs, but those drugs account for 25% of the total US drug spending.<sup>9</sup>

The current trends in increased utilization and spending for specialty drugs are expected to continue, placing burdens on all healthcare stakeholders. In particular, insurers or other third-party payers and manufacturers will be challenged to develop novel approaches to for-

mulary design and pricing practices that ensure patient access. Diagnostics, drugs, and devices continue to drive the overall care spending. In the short term, in the midst of uncertainty regarding the biosimilars market and the rapid innovation in personalized medicine beyond 2015, plans and pharmacy benefit managers will continue to focus on unit cost-savings. The longer-term impact of the current trends is now being recognized by commercial and self-funded plan sponsors, along with how best to manage the economic risk over time. This issue alone could change the structure of insurance product offerings and consumer coverage by 2017.

At the same time, these trends are affecting pharmacy practice. Specialty pharmacy is transforming from a drug distribution model to an integrated system that coordinates many aspects of patient care, enabling health plans to manage populations across all benefits and distribution channels. In parallel, the emergence of personalized medicine is revolutionizing the treatment paradigm for a growing number of disease states. As a result, there is a need for a sophisticated understanding of treatment plans and pathways, a need that can be filled by specialty pharmacy programs. This also changes relationships across stakeholders as roles shift, blend, or change from traditional practices in the next few years.

With the increasing availability of tools and mobile applications, new avenues for patient engagement and new healthcare delivery roles are emerging or are rapidly changing. The location of care is shifting from the hospital to the home, and the focus on improving patient health and well-being is increasingly becoming a community-wide effort. Technology and computing trends are quickly embraced by younger consumers, as well as by new-age wellness providers who assist older populations in making decisions about their healthcare options. The improved access to information, including cost, has been identified as a “game changer” that will affect all care provider roles through the end of this decade.

Because infused drug therapies can be administered in a hospital, physician’s office, infusion center, or even in the patient’s home, costs related to where the drug is administered can vary significantly. For example, the costs for a standard dose of a treatment for rheumatoid arthritis can vary from \$3259 for the drug and \$148 for administration when infused at the patient’s home to \$5393 for the drug and \$425 for administration when infused as an outpatient procedure at a hospital. In fact, the hospital setting is typically the least cost-effective site of care for infusions.

According to a recent CVS report, infusions are increasingly being done in a hospital setting, where the costs for the drug and its administration can be the highest of all potential sites of care.<sup>10</sup> As previously mentioned, this is



unlikely to continue in the long-term, and the market will drive other behaviors by providers or systems through altered revenue dynamics. We have already seen this phenomenon with diagnosis-related groups, ambulatory visit groups, and Surgical Care Improvement Project payments to hospitals, to name a few.

Newer oral and self-injected drugs will also be changing the costs that are associated with the site of care.

### **Information Technology Innovations Drive Interstakeholder Communications**

Innovations in computing and big data services are changing the way health information is recorded and delivered between patients and providers. Electronic health records (EHRs) and electronic medical records (EMRs), clinical documentation tools, and telemedicine devices are changing the way that providers collect and consume health information regarding their patients.

US physicians and consumers are increasingly ready to embrace a dramatic expansion of the “high-tech” personal medical kit. Wearable technology, smart-phone-linked devices, and mobile applications will become increasingly valuable in the delivery of care. A proliferation of approved and portable medical devices in patients’ homes and on their phones makes diagnosis and treatment more convenient, redoubling the need for strong information security systems.<sup>11</sup>

Electronic activity monitors (also known as trackers or wearables) are quickly gaining popularity with consumers for tracking physical activity, heart rate, sleep patterns, calorie consumption, and more. Companies such as Nike, Fitbit, Jawbone, and Garmin currently offer a range of wearables, with varying features and price points. The Apple Watch, which is expected to launch in 2015, will include the HealthKit software, which collects data from the user’s health and fitness applications for centralized access to health information. It is estimated that between 10% and 15% of consumers in the United States own wearables, with 61% of those devices being activity trackers.<sup>12</sup>

Start-up companies that offer applications for iPhones or Android devices are proliferating in healthcare. Providing a new solution or a new approach to managing a disease (eg, diabetes or asthma), and integrating general wellness with the early management of a disease or condition (eg, heart disease, high cholesterol) are primed areas for growth in the next few years. This is a result of the consumer adoption of the technologies, as well as investment in information technology applications for healthcare by angel investors or venture capital groups.

Privacy, despite HIPAA/HITEC violation concerns, will lose ground to convenience in 2015, as patients

adopt digital tools and services that gather and analyze health information. Although numerous positive applications of these electronic activity monitors exist, there is always the possibility for unintended adverse consequences or ethical dilemmas. The potential for the sharing of global positioning system location data and personal health information produces clear privacy concerns. Surveillance of the collected data by healthcare providers may also lead to situations where intervention is deemed ethically necessary. Clear protocols will be necessary to guide provider behavior in such cases and to reduce the risks associated with potential privacy breaches.<sup>13</sup>

The application of data and analytics to patient care provides novel opportunities for improving care effectiveness and efficiency. Still, the full potential for data-driven insights to revolutionize care is hampered by the current data input and output limitations of medical record systems, the lack of a robust business model for interoperable data exchange across organizations, and broader organizational barriers that require coordinated solutions across stakeholders. Addressing those barriers and alternative revenue for a sustainable solution has become an increased focus of attention for many investors and public health advocates alike. This trend will likely intensify during the next couple of years to be in place when EMR and EHR software selections are finalized.

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The Medicare and Medicaid Electronic Health Care Record Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

In 2013, 59% of hospitals have adopted at least a basic EHR system. This represents an increase of 34% from 2012 to 2013 and a 5-fold increase since 2008. In 2013, 93% of hospitals possessed certified EHR technology, increasing by 29% since 2011.<sup>14</sup>

Information technology is an area within healthcare that clearly crosses many disciplines while offering some of the greatest return on investment for healthcare delivery solution implementation. Chief information officers and

their chief medical officers in systems and plans are very focused on finalizing the implementation of EMRs, at the same time that employer plan sponsors are seeking access to that information in real time. Patients are now jockeying for a seat at the table, because there is a light at the end of the information technology tunnel in this decade.

Going forward, new technologies will more quickly empower patients and providers to enhance practices for managing and coordinating healthcare. The effective widespread use of new technology tools may require increased data transparency, patient education, and the coordination of tools across the growing range of technology options.

**Personal or business consequences related to these trends will be important for all stakeholders to remain aware of and to prepare for their impact. Individual stakeholders will have to innovate or adapt to these trends, and understand their impact on clinical care decision-making.**

## Conclusion

Change and the more rapid, broad-based effect of change have impacted all healthcare stakeholders since 2010 and the passage of healthcare reform in the United States. Although many early changes in the healthcare market have been widely published, trends that are tracing locally early or are still emerging nationally need to be identified to better prepare for success in the healthcare market. High-level trends identified here will impact healthcare roles and decision-making. These trends have the ability to continue the market transformation and to impact relationships among multiple stakeholders.

Personal or business consequences related to these trends will be important for all stakeholders to remain aware of and to prepare for their impact. Individual stakeholders will have to innovate or adapt to these trends, and understand their impact on clinical care decision-making.

The clinical care decisions that are increasingly shared among the various stakeholders will have to bal-

ance the economic and the clinical consequences among stakeholders. Already occurring in oncology care, this new reality cannot be avoided, and change is difficult. Being aware of tracing early, as well as of emerging trends, can assist each healthcare stakeholder to be better prepared and can drive innovation that could alter an adverse movement of a trend. ■

## Author Disclosure Statement

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